"Back off means stay with me". Perceptions of individuals with mild intellectual disability or borderline intellectual functioning about the group climate in a secure forensic setting

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Abstract

Purpose – *The purpose of this study is to provide an in-depth account of how individuelas with a mild intellectual disabilitiy or borderline intellectual functioning (MID-BIF; IQ 50–85) perceive their group climate in a secure forensic setting. Giving voice to these service users may provide relevant insights for secure forensic settings.*

Design/methodology/approach – *The interpretative phenomenological analysis was used to explore what individuals with MID-BIF experience with regard to their group climate.*

Findings – *In the interviews about the four domains of group climate (i.e. repression, support, growth and atmosphere), five overarching dimensions appeared, namely, autonomy, uniformity, recognition, competence and dignity. Depending on the person and the (treatment) context in which he/she resides, these five dimensions relate to all four factors of the group climate instrument.*

Originality/value – *From the perspective of individuals with MID-BIF, this study contributes by providing a framework to "fine-tune" group climate on five dimensions. Training socio-therapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimizing group climate in secure forensic settings.*

Keywords *Group climate, Mild intellectual disability, Borderline intellectual functioning, Secure forensic setting, Interpretative phenomenological analysis*

Paper type *Research paper*

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Perceptions of individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF) about the group climate in a secure forensic setting.

A therapeutic group climate is related to positive therapeutic outcomes, such as motivation, coping, therapeutic alliance, recidivism and organizational outcomes including staff and client satisfaction and less aggressive incidents (Gaab *et al.*, 2020; Willets *et al.*, 2014). Moreover, the Dutch Government underlines the importance of a safe and humane climate that encourages self-reliance and a safe return to society in its policy for correctional settings (Boone *et al.*, 2016). Therefore, secure forensic settings monitor their group climate as a standard practice to inform their on-going quality improvement (De Vries *et al.*, 2018; Neimeijer *et al.*, 2019; Tonkin, 2015). An example of a monitoring instrument is the group climate instrument (GCI), which was developed to measure group climate in youth prisons

and secure residential treatment facilities and is nowadays used in youth prisons, secure youth care facilities, forensic mental hospitals, adult prisons and residential care facilities for individuals with mild intellectual disabilities (Van der Helm *et al.*, 2011; Stams and Van der Helm, 2017). Although short self-report questionnaires such as the GCI are relatively easy to use in clinical practice, these instruments measure a simplified construct of group climate. Therefore, some studies advocate for a more in-depth insight and operationalization of group climate, for example, through individual interviews with clients about their group climate (Doyle *et al.*, 2017).

Although the relationship between group climate and therapeutic and organizational outcomes is well-researched and documented in secure forensic settings, less attention has been paid to group climate in secure forensic settings for individuals with MID-BIF; IQ 50–85 (Robinson and Craig, 2019; Willets *et al.*, 2014). That is remarkable given the fact that the prevalence of individuals with below average or low intelligence is high in such settings (Vincenzutto *et al.*, 2018). Until now, no studies have provided an in-depth account of how individuals with MID-BIF perceive their group climate in secure forensic settings (Bell *et al.*, 2017; Robinson and Craig, 2019). Giving voice to these service users may provide relevant insights to develop a therapeutic climate that meets the needs of individuals with MID-BIF to facilitate overall well-being and positive treatment outcomes. Therefore, in the present study, we used interpretative phenomenological analysis (IPA) as a qualitative method to explore what individuals with MID-BIF experience with regard to their group climate. IPA is a suitable approach to explore how individuals perceive situations they are facing, and how they make sense of their personal and social world (i.e. their group climate). IPA studies typically have small sample sizes, allow for in-depth engagement with each individual case, and a detailed exploration of similarities and differences between participants (Smith *et al.*, 2009). By using IPA, we aimed to develop a better understanding of the unique experiences, challenges and needs of individuals with MID-BIF in a secure forensic setting with regard to their group climate. It is expected that both helpful and unhelpful aspects of group climate would be identified by the participants. Following the qualitative and explorative nature of the current study, no hypotheses were formulated (Korstjens and Moser, 2017).

Method

Setting and participants

The present study was conducted at Trajectum, a Dutch secure forensic treatment facility for adults with MID-BIF and externalizing behavior problems and/or internalizing problems. Because of a combination of MID-BIF, severe challenging behavior, mental health problems and/or a history of substance abuse, all residents need intensive care and monitoring in a specialized and secure setting. Most residents have committed a serious crime and are admitted by means of a disposal to be treated on behalf of the state (in Dutch: Terbeschikkingstelling) as they were considered not to be legally accountable for their crime because of severe psychopathology. Other residents are placed in the facility under criminal law, civil law or were voluntarily admitted.

Treatment is provided by socio-therapists [1] during daily routines, work and educational activities, individual and group therapy sessions and leisure activities in collaboration with psychologists, psychiatrists and psychotherapists, who supervise the socio-therapists and provide additional one-to-one treatment. Based on the psychopathology of the residents and the phase of the treatment (i.e. observation, treatment and rehabilitation), treatment programs (e.g. aggression, addiction or sexual offending behavior), the security levels and care intensity vary over the units (i.e. observation, treatment and rehabilitation). While in some units the support is more distant, in other units, the residents receive one to one guidance throughout the day. Depending on the risk of (re)offending, legal status and

treatment phase, residents move to living groups with different levels of restrictions and levels of security.

Based on variability in characteristics on participant level (gender, age, diagnosis, legal status, treatment duration at the living group and the facility, treatment phase) and group level (security level, care intensity, group composition, group size and treatment program) participants were invited to participate. A purposive sampling strategy was applied to ensure variability in experiences among the participants. In total, 12 individuals (4 women; 8 men) with MID-BIF participated in the study. Their pseudonyms and characteristics are provided in Table 1.

Data collection

Data were collected in tranches between November 2018 and October 2019. Oral and written information was given to participants, their legal guardians and treatment teams concerning data collection, study aims, objectives and that data were treated confidential and anonymous. A multidisciplinary treatment team consisting of a socio-therapist, a psychologist and a psychiatrist determined whether a participant was able to give informed consent and to participate. Residents with severe and acute psychotic problems were excluded in accordance with ethical guidelines with regard to legal capacity. All included participants, and if applicable their legal guardians, gave their oral and written consent. Ethics approval for this study was granted from the Ethics Committee of the Faculty of Social Sciences of the Radboud University (ECSW2017-3001–471). The COREQ criteria list for qualitative research was used to guide the analysis and report (Tong et al., 2007).

In line with the IPA method, we used semi-structured interviews (Smith, 2011; Smith and Osborn, 2008). A topic list with visual support about group climate was used to guide the interviews. Consistent with the four subscales of the GCI (Neimeijer et al., 2019; Van der Helm et al., 2011), the central topics of the interviews were support, growth, atmosphere and repression. First, the interviewer asked the participant, which topic was most important to them (e.g. "if we look at these four domains of the group climate (support, growth, atmosphere and repression), which element do you think is the most important to you?") and stimulated them to share concrete experiences on this topic (e.g. how does the participant view the kind of support he/she is given or how do the participant and socio-therapists get along). Also, participants were asked to give examples of a "good" and a "bad" day on the living group.

Interviews were carried out in an open and flexible manner with topics being covered according to the direction taken by the participants, aiming to initiate a dialogue with participants, while remaining open to other subjects raised by the participants themselves. At the end of the interview, participants were given the opportunity to mention additional topics. The interviews were conducted by the first and second authors who are licensed psychologists with extensive experience in working with individuals with MID-BIF in a secure setting. The interviewers used a not knowing attitude and asked in depth about concrete examples of situations, behavior of socio-therapists and own experiences of the clients. The duration of the interviews ranged from 25 min to 58 min with a mean duration of 37 min. The interviews were audio-recorded with the participants' informed consent and transcribed (verbatim) for coding purposes. Afterward, the audio recordings were deleted.

Analysis

The transcribed interviews were analyzed using IPA. IPA can be used for a detailed exploration of how people make sense of their personal and social world by exploring an individual's personal perception or experience as opposed to an objective description of the object or event itself (Smith and Osborn, 2008). IPA is a dynamic process based on the assumption that the researchers have an active role in the research process and influence

Table 1 Pseudonyms of the participants and their individual and treatment characteristics

				Individual characteristics		Treatment characteristics					
Pseudonym	Gender	CA (in years)	Level of functioning	Additional diagnoses	Legal status	AT facility	AT group	Treatment phase	Security level	Care intensity	Treatment program
Oliver	m	39	BIF	PTSD, personality disorder, schizophrenia or other psychotic disorders, substance abuse, gambling disorder	Criminal law	Five years, one month	3 years, 11 months	Closed treatment	Closed setting within the clinic	Normal: 2 on 8	Sex offenders program
Jack	m	34	BIF	Sexual disorder, personality disorder	Criminal law	Seven years, one month	One year, nine months	Closed treatment	Closed setting within the clinic	Medium high: 3 on 8	Sex offenders program
Harry	m	28	MID	ASD, schizophrenia or other psychotic disorders, substance abuse, attachment disorder, depressive disorder	Civil law	2 years, 10 months	Eight months	Semi-closed treatment	Semi closed on the property of the clinic	High: 4 on 8	Individual program
Sophie	f	35	BIF	PTSD, personality disorder, depressive disorder	Civil law	Seven years, six months	Three months	Resocialization	Semi closed on the property of the clinic	Medium high: 3 on 8	Outflow program/last phase treatment program
Charlie	m	25	MID	ADHD, PDD NOS, Personality disorder, aggression regulation problems	Civil law	Four years, one month	Three years, five months	Closed treatment	Closed setting on the property of the clinic	Medium high: 3 on 8	Individual program
Thomas	m	28	BIF	ASD, sexual disorder, personality disorder	Criminal law	Three years, one month	Four months	Closed treatment	Closed setting on the property of the clinic	Normal: 2 on 8	Sex offender program
Laura	f	33	MID	PTSD, personality disorder, schizophrenia or other psychotic disorders Substance abuse, obsessive compulsive disorder	Civil law	Seven years, one month	1 year, 10 months	Closed treatment	Closed setting within the clinic	Very high care: 4 on 6	Individual program
Rachel	f	45	MID	PTSD, personality disorder schizophrenia or other psychotic disorders, substance abuse	Criminal law	Four years, nine months	One year, nine months	Closed treatment	Closed setting within the clinic	Medium high: 3 on 8	Group addiction program
Oscar	m	18	MID	ADHD, social contact disorder	Civil law	Five months	Four months	Observation	Closed setting on the property of the clinic	Medium high: 3 on 8	Inflow program/first phase treatment program
James	m	43	BIF	ASD, schizophrenia or other psychotic disorders	Criminal law	One year, four months	One year, four months	Closed treatment	Closed setting within the clinic	Medium high: 3 on 8	Group aggression program
Emily	f	22	BIF	ASD, schizophrenia or other psychotic disorders, attachment disorder	Voluntary	Five years, six months	Five months	Resocialization	Semi closed on the property of the clinic	Normal: 2 on 8	Outflow program/last phase treatment program
William	m	33	MID	ADHD, attachment disorder, substance abuse	Civil law	Two years, four months	Two years, three months	Closed treatment	Closed setting within the clinic	High: 4 on 8	Individual program

Notes: F = female, M = male, BIF = borderline intellectual functioning; MID = mild intellectual disability; ADHD = attention deficit hyperactivity disorder, ASD = autism spectrum disorder; PTSD = posttraumatic stress disorder; PDD-NOS = pervasive developmental disorder – not otherwise specified; AT facility = admission time in the facility; AT group = admission time at the group, care intensity: 2 on 8 = 2 staff on eight clients (client staff ratio)

the extent to which they access the participant's experience and how they interpret and make sense of that experience. The clinical experiences of the researchers are important to be able to properly interpret the experiences of the client in the light of their complex problems and the unique context in which they reside (Zomerplaag, 2017). Therefore, we thought IPA better suitable than other procedures such as grounded theory (Glaser and Strauss, 1967) and thematic analysis (Braun and Clarke, 2006).

Data analysis was carried out by the first and second authors independently and followed the stages set out by Smith *et al.* (2009). The first stage involved the close reading and rereading of the transcript to become familiar with the interview content. Second, the transcript was read line by line, noting points of interest and significance on a descriptive, linguistic and conceptual level. Third, the transcript and initial notes were reread, with emergent themes noted. At the fourth stage, themes that were considered as connected were grouped into overarching themes and given a descriptive label, after which these groups of themes were discussed within the research team. As a result, some additional changes were made in the grouping or descriptive labeling of themes. To ensure that the analysis was carried out in a rigorous way and that interpretations made by the first and second author were of an explicit nature, all stages involved a discussion with a third researcher to provide an audit of the analysis. These stages were repeated for each transcript after which the overarching themes for each interview were compared and discussed with the research team to find patterns across cases. After 12 interviews had been reviewed, no new theoretical aspects emerged from further coding and comparison and saturation was reached (Mason, 2010). The dimensions and themes that emerged during interviewing and analysis are reported in a tabulated outline (Table 2). Expert checks were carried out with the fourth and fifth authors who are experts both in forensic care for individuals with MID/BIF and group climate.

Results

In all interviews, we identified five overarching dimensions that might help socio-therapists to optimize the four factors of the group climate (i.e. support, growth, repression and atmosphere) at an individual level (Figure 1). These dimensions are, namely, autonomy, uniformity, recognition, competence and dignity.

Autonomy: Give me guidance and space

I don't like that [when sociotherapist are strict]. That way you will never become independent. [...] The sociotherapists should have protected me by not letting me go on my own. But they left me on my own [...] I was constantly taking drugs and I was constantly using again. (Charlie).

Table 2 Tabulated outline with dimensions and themes		
Topic	*Dimension*	*Themes*
Group climate (support, growth, atmosphere and repression)	Autonomy	Guidance, personal space, structure, rules, (in)dependency, protection, safety, self-determination, control, limits, clarity, predictability, dominance, risky behavior
	Uniformity	Individual approach, group approach, exceptions, uniqueness, belonging, feeling disadvantaged, equality, fairness, cohesion
	Recognition	Being seen, being heard, understanding, without words, trust, empathy, presence, proximity, responsibility, connection, professional distance, engagement, contact
	Competence	Challenge, possibilities, disability, meaning, strength, feedback, daily activities, encouragement, short term, long term, perspective, development, expectant acceptance, meaningful involvement, coping, personal growth, small steps
	Dignity	Humanity, disability, disorder, coercive measures, us versus them, honesty, privacy, identity, self-esteem, individual needs, normalize, ordinary

Figure 1 Five overarching dimensions as a "mixing console"
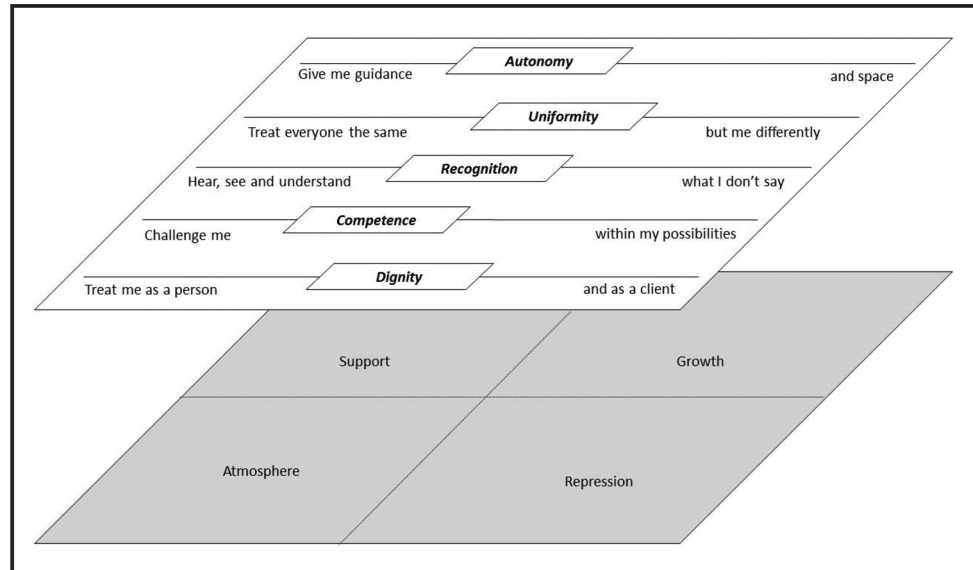
> [When clients don't obey the rules] it is important that there is structure and the sociotherapist talks to the client [. . .] When . . .the sociotherapists are in the office, I feel unsafe. Then I am afraid that I will be touched and use violence. If the sociotherapists are there, it does not happen [. . .] I like it when a sociotherapists makes jokes and doesn't pay strict attention to what I am doing. There are also sociotherapists who are very strict, just like prison guards. It might be better for me if someone is strict and watches over me. Some sociotherapists say nothing, while it is better if they do say something (Rachel).

All participants discuss the limitations in their autonomy that they experience with regard to their privacy, freedom of movement and self-determination at different levels and how these limitations frustrate them. Sometimes they refer to small and everyday things, such as the kitchen cupboards that are locked or that they (cannot) choose, which toppings they would like to have on their bread. At other times, it concerns matters that have a major impact on their lives, such as the granting of leave or the extension of their obligatory treatment. At the same time, they realize that these restrictions in autonomy are necessary to ensure the safety and quality of life in the groups and to protect society and/or themselves. According to the patients, it is important that socio-therapists understand when and in which situations they should give the person space and when not. This decision is complex because the potential safety risks and the autonomy of the person compete with each other and risk behavior is related to various individual and contextual factors, which change over time. For example, Charlie emphasizes at the beginning of the interview that it is necessary for his recovery to increase his independence, while later in the interview he talks about the moments in which he, due to a lack of supervision, uses drugs:

> If I go outside the clinic, I first think about how much time I need and then I discuss this with the sociotherapists. Then we make the appointment together. I like that (Harry).

> I am not a twelve year old child. We are all adults, and that is sometimes forgotten. Please note that the way people say things makes it more or less easy for me to accept things and that it should above all be a respectful way of saying things and not an authoritarian one (Oscar).

> I would like to see a prostitute. [. . .] Then I was told that it was not possible yet. I would like to see them explain and tell me what they expect from me. I want to know why it's not possible and what I have to achieve, own or control so that I do can go there (Thomas).

When rules, boundaries and agreements are nevertheless used as a means to provide support and safety, the participants, such as Harry, Oscar and Thomas, indicate that it is important that socio-therapists do this in a respectful and mature way, explaining to them why these measures are being taken. Participants, such as Harry, would also like to have a voice in how these restrictions look like and they want these restrictions to be enforced in a consistent manner because failure to enforce them consistently leads to uncertainty and can lead to an increase in problem behavior. Finally, the participants, such as Thomas, would like to know how, when and in what way these restrictions in autonomy will be settled. According to participants, it is crucial that the socio-therapist understands their individual characteristics and the relative need for support in relation to the individual need for space and autonomy.

Recognition: Hear, see and understand what I say and what I do not say

In the beginning people thought when I was angry and when I cursed and raged: oh, he is losing his mind again. But you can also ask yourself, what's going on in his head? What is going on? Could we solve those puzzle pieces? […] Sociotherapists shouldn't pretend to be some kind of superman who can help all the people here. Or that they have life experience […] If you have experienced the same as I did you would also be here in this clinic, you would also have been to prison […] It's better to say: ''I understand your situation''. Well, that's another thing. Better: I try to understand. But not: I understand, because you don't understand! (Charlie).

Sociotherapists should notice when things are not going well, even if I do everything to put on my mask. It is not always easy to tell people everything when you don't know them very well. I always take precaution first and then I talk to someone. […] It is part of the knowledge of the sociotherapists that they know what someone needs […] If I had talked earlier I could have prevented self-injury, that is not due to the sociotherapists because they couldn't have seen it come (Sophie).

These quotations show that clients demonstrate internalizing and externalizing behavior that has led to such a great risk or problem that 24-h support and supervision is necessary. Participants expect socio-therapists to view their behavior as a symptom of an underlying problem or need and that they are able to analyze and anticipate this behavior. Instead of responding to the externalizing behavior of Charlie, the socio-therapist should pay attention to his underlying fear and uncertainty and anticipate to his need for affinity (Anglin, 2014). This is difficult because the observable behavior often deviates from the implicit and unspoken message and many clients try to mask their underlying problems (Charlie: "back off means stay with me"). Nevertheless, participants feel that socio-therapists should have the knowledge and skills to interpret their ambivalent signals properly because of their education and work experience.

Listen to you … Don't twist things and be open and honest. And they have to trust me, because otherwise it makes no sense… If people do not keep their promises, my confidence will drop again (.) the sociotherapists must keep their promises and I must be open and honest (Jack).

The sociotherapists should ask more questions and assume less (Thomas).

The sociotherapist should be less often in the office, but be more involved with the group, such as a sociotherapist [who] comes to you on his own initiative [and has] a normal social conversation [with me]. If I just sit in my room all day, I don't think they will come to my room. No, why is he sitting there in his room all day, is there something going on? (James).

The participants consider it the task of the socio-therapist to interpret their symptoms correctly to unravel the underlying function of the behavior and to intervene on it. Therefore, the socio-therapist must get to know them well as a person and build and maintain a relationship of trust. For this, the socio-therapist, as James describes, must be present in the group, take the initiative for (normal) contact, not to judge, be patient and show interest

in getting to know the person. Only when the person trusts the socio-therapist can he, through questions and listening, gain insight into the coping and underlying problems of the person.

Uniformity: Treat everyone the same, but treat me differently

> You have not chosen the ones you are in a group with […] If someone is angry, that also triggers you. […] I suffer from that. […] when I have been on leave and come back to the group, it feels good (Laura).

> Look, you're staying here with eight people. If you say something wrong, it can get nasty, that makes me nervous […] You shouldn't interfere with other clients and focus on yourself […] […] People don't just use [drugs] without reason, talking about it [in group therapy] helps (Rachel).

> It is positive that we are one group and that we trust each other . . . when a new client comes, you first have to see whether you can trust them (Oliver).

The participants gave many examples that showed an ambivalent attitude about living in a treatment group. Participants emphasized that living with people who are different from themselves and often show complex, dangerous and unpredictable behavior in a secure setting that they cannot leave, is tiring and evokes negative emotions and behavior as they must continuously adapt to other residents and be alert for potentially dangerous situations. As a result, participants are often anxious or tensed, especially, like indicated by Oliver, when a new resident joins the group. Finally, the participants refer to negative consequences (e.g. restrictions in their freedom of movement) as a result of the problem behavior of another person. In general, most participants do not prefer to live in a group. However, all participants described that they belong to the group and/or feel at home as the group members offer them sociability and support. Participants want to spend time together, participate in activities and be treated and addressed as members of their living group. However, at the same time, there is a (strong) need to be seen and treated as an individual, especially when the participants discuss the structure and rules within the clinic. Although participants emphasize the need for uniformity regarding routines, rules and clear agreements, they also stress that when routines and rules are too strict and no individual exceptions can be made, this will result in (behavior) problems. This ambiguous attitude toward rules and agreements is formulated by Laura: *I think the rules and agreements should be the same for everyone. […]. I think that rules should be made per person.*

As socio-therapists are responsible for maintaining the atmosphere and safety in the group, participants expect socio-therapists to take into account their need for equal treatment and clarity about rules, but at the same time, they should have an eye for the individual characteristics of the person and find ways to avoid uniformity and group agreements, so that they can meet the individual needs of the participants. According to the participants, it is important to justify an individual exception to the person, the group and other professionals within the organization.

Competence: Challenge me within my possibilities

> It is difficult to find a good place for me to live. I have an aggression and drug problem […] There are only two institutions that are willing to take me […] You have to wait very long before you can move to the next step. […] Sometimes I went too quickly to the next stage of treatment, the step was too big […] my future is my downfall. I am actually well at my current living group (Charlie).

> If someone says you are a mission to fail, that may be meant as a joke, but it makes me feel like shit […] I want people to start the treatment with me so I can make it to the next step. Therapy is important, but pottering is just as important to me.

In the future I want to live somewhere, with a dog and my daughter . . . That sociotherapists come to visit me three times a week or something. [. . .] I prefer to be out of psychiatry, but that will probably not happen any time soon, but with an extra step in between (Laura).

Most people strive for a meaningful life and for most participants initially this means a normal life. During their treatment, participants come to realize their vulnerability and long term support need, which changes their perspective on the future. In the interviews, participants struggle with the acceptance of their disability and support needs, and the need for perspective with regard to the possibilities and dreams for the future, such as Laura. Although the perspectives on the future differ between individuals and are related to the phase and duration of the treatment and the support they receive, all participants look for a meaningful use of time within the clinic.

Like James, the participants refer to therapy, which contributes to long-term goals and, on the other hand, to activities, such as crafts, that contribute to a meaningful interpretation of the day. All participants indicated that it is important that you have a sense of feeling of independence, that you achieve something and that you have the idea that staying in the clinic makes sense. In their interviews, the participants sometimes refer to small and everyday successes, such as selling a homemade flag line made during daytime activities, preparing a meal for the group, a homemade rap or the certificates obtained for therapy. At other times they talk about moments that have a major impact on their lives in the long term, such as moving to a different stage of treatment or place of residence or contact recovery with family.

I would like to move to another place, rather today than tomorrow. What I really miss is that people don't inform me about how we are going to proceed, what else do they expect from me? [. . .]. I have to ask questions about everything. Then I think, does that necessarily mean that I have to come to you and cry? I was recently told that I was nagging too much, and then they told me again, well, you also have to ask. Then I think: 'What do you want? Be straight!' (Jack).

Socio-therapists should pay attention to the limitations of the person and offer the person sufficient support by offering the person a day program in which there is a good balance between rest and meaningful activities and adequate verbal or physical prompting during tasks to gain successful experiences. On the other hand, they should pay attention to the longer term perspective of people who because of their complex problems and the context in which they find themselves, often have limited opportunities to achieve a more dignified, more experience-rich existence in a meaningful context. As the participants' ability fluctuates during the day, socio-therapists must continuously estimate what the person can handle at that time and in that situation and what support the person needs to undertake the activity. However, by undertaking positive activities together, which are in line with the capacity at that time, there is room for successful experiences in relation to self-image and appreciation and in relation to the socio-therapists. Although the participants recognize the importance of a phased treatment that is offered in small steps, the small steps and the lack of a clearly outlined future perspective also frustrate them. At the same time, most people are unable to sketch a written and complete treatment process because they often cannot oversee this and are focused on all things that have "not yet started." This leads to negative thoughts about themselves, the treatment and the treatment environment as a whole, which is also referred to as loss of perspective.

Dignity: treat me as a person and as a client

Those very small and simple things can make you very happy. And then there are those very small simple things that do not fit, which can make you unhappy. It would help if the sociotherapists took more initiative to come to me. Then I feel that I do matter [. . .] He [a sociotherapist] treats you as a human being, explains things well and listens [. . .] It gives a bad

feeling if they rather see you come than go [...] As the sociotherapists say: 'It was nice to go with you outside of the clinic', it makes me feel good (James).

All participants state that it is important to them that socio-therapists do not see them as a client or their work, but as a person. According to them, the person must be central in their care instead of the offense, the disorder and/or the disability (Barnao *et al.*, 2015; Griffith *et al.*, 2013). Participants want an equal, sincere and reciprocal human-to-human collaboration between therapist and client. At the same time, the participants want a professional with clinical expertize with sufficient knowledge and skills to unravel their problems and needs and intervenes accordingly. The participants see initiating and maintaining the relationship between the therapist and participant as part of the socio-therapists' tasks and responsibilities. Therefore, socio-therapists must have sufficient knowledge and skills to initiate and maintain this contact, even if the participant does not collaborate.

> My brother died last year suddenly, at the age of 22. That was a tensed situation for me [...] sociotherapists took really good care of me [...] Those days after his death I was not feeling well and constantly sad. And then the sociotherapists said: We are not going to stay here for lunch [...]. Then we made a sandwich together, we cycled to the camping and had lunch there with the two of us (Emily).

Instead of planning a meeting at the unit or a conversation with Emily's psychologist about her grieving process, her socio-therapist chooses to picnic with her at a campsite near the clinic. They reminisce about her brother and talk about the loss. At that moment she was approached primarily as "a human being" instead of as a client. At the same time, the socio-therapist must remain alert to signals that indicate a potential dangerous situation for Emily and/or her environment. In day-to-day interactions, socio-therapists should navigate between the role of fellow human beings who interact with the client in a cooperative, equal and dignified manner and offer a human existence within the clinic and between the role of professional who approaches the client using their clinical expertize and skills.

Discussion

This study established an in-depth account of the experiences of 12 individuals with MID-BIF about their group climate in a secure forensic setting. In the interviews about the four domains of group climate (i.e. repression, support, growth and atmosphere), five overarching dimensions appeared, namely, autonomy, uniformity, recognition, competence and dignity. Depending on the person and the (treatment) context in which he or she resides, the five dimensions relate to a greater or lesser extent to all four factors of the GCI (Figure 1). For example, the dimension of competence was connected to experiences related to the domain of growth, while the themes of autonomy, dignity and uniformity were strongly linked to experiences related to the domain of repression. In the interviews, the dimensions follow each other at a rapid pace and reinforce each other, as can be seen in the following quote:

> If someone calls you a mission impossible, that might be a joke, but it gives me a bad feeling [...] I recently made a very nice soapstone turtle. That turtle has become so beautiful, so beautiful! It is now exposed in a museum. It would be really cool if someone buys it (James).

James refers to a moment in which he feels competent – "museum-worthy soapstone turtle" – and experiences incompetence – "mission impossible" – (dimension: competence). In addition, he talks about his self-esteem (dimension: dignity) and whether or not he is seen and heard by socio-therapists (dimension: recognition). This example illustrates that there are not five separate dimensions, but five dimensions that, as sliders on a mixing panel, must be continuously adjusted and in interaction by the socio-therapists for several clients at the same time.

When I am tense, I like that staff is with me. But when I'm mad they got to leave me alone (William).

When I say that everything is going well, staff has to understand that it is not going well at all, they have to get through (Rachel).

Back off means stay with me (Charlie).

As can be seen in the quotes above from William, Rachel and Charlie, all participants gave ambivalent views about group climate in general and the support from socio-therapists in particular. For example, when Rachel indicates that she is doing well, this sometimes means that she is actually doing well, while this is not the case at other times. However, she expects, like the other participants, that socio-therapists can interpret her behavior correctly and anticipate as the participants are not able to express their needs in everyday situations and regularly send out verbal en non-verbal signals that conflict with their need for proximity from socio-therapists.

In addition, signals from participants, as in the quote from William, sometimes appear to differ only subtly ("tension" versus "anger"), while socio-therapists are expected to behave in opposite ways as they have to give him space when he is angry and comfort him when he is tensed (proximity versus space). Finally, the signals and support needs vary greatly between participants and over time. Where socio-therapists have to leave William alone when he is angry, Charlie needs the proximity of socio-therapists in a similar situation.

This indicates that it may be impossible to formulate a uniform, optimal group climate for individuals with MID-BIF in secure forensic care, but that a therapeutic group climate varies per person, per situation and over time. Socio-therapists are expected to receive the subtle and ambivalent signals sent out by the participants, to interpret them correctly within that specific context and intervene accordingly. This implies that group climate is a dynamic concept in which socio-therapists must continuously attune their actions to the ambivalent signals of multiple individual clients at the same time. This is even more complex because of the ambiguous task of the professionals in this forensic context (i.e. the therapy-security paradox; Inglis, 2010; Jacob, 2012) as they have to assess and manage risks while at the same time building and maintaining a therapeutic relationship and anticipating to the needs and requirements of clients. This paradox has been the focus of scientific research for decades. The risk, need and responsivity principles of Andrews et al. (1990) has been the basis of most rehabilitation and treatment programs for delinquents to date and focuses primarily on risk management and relapse prevention. As a counterpart, the Good Lives Model (Ward, 2002; Ward and Stewart, 2003) focuses mainly on promoting the well-being of the delinquent and focuses on the strengths and capacities of the individual. In the ID-literature positive behavior support has received increased attention (Davies et al., 2015). Although these theoretical frameworks have proven to be useful within forensic care, it remains difficult, as can be seen in this study, to translate these frameworks from general directions to specific guidance for the unique person in his or her specific context. As in complex care, on the one hand, you need "big K knowledge," based on research, captured in publications and transmitted through training and education. As seen in this study, also "small k knowledge" is important, based on personal experiences and is the result of the own thinking of socio-therapists, that can be used to make the fit with the person (Zomerplaag, 2017). This complicates the work of the socio-therapists in forensic care for people with MID-BIF; working at the intersection of forensic care, psychiatry and care for individuals with intellectual disabilities. This should be integrated flexibly, taking into account different perspectives, proven methods and (legal) frameworks.

A few comments should be taken into account when interpreting the results of this study. As with any study using IPA, this study provides insight into how a small number of participants who are part of a specific target group experience a specific phenomenon. This means that

the results should be interpreted with caution in relation to generalizability to the population of individuals with MID-BIF in secure forensic care. Follow-up research must show to what extent the five overarching dimensions are specific for forensic care for persons with a MID-BIF or whether these dimensions are also present to a greater or lesser extent in the regular care for persons with a MID-BIF or within forensic care for individuals without MID-BIF. A second comment that should be made is that the four factors of the GCI (i.e. support, growth, atmosphere and repression) were used to operationalize group climate within this study. Given that group climate is measured by the GCI within this setting (Neimeijer *et al.*, 2019, 2020), we believe that this is an appropriate choice. Another topic list with regard to group climate might have led to other dimensions. Another comment is that in IPA the researcher is in essence adopting two positions; one, which attempts to see the world from the perspective of the participant, and in effect stand in their shoes (the insider perspective). The other position is that of self-conscious and systematic explorer of the participant's perspective (the researcher perspective). It should be acknowledged that the actions and decisions of the interviewers will inevitably impact on the meaning and context of the experience under investigation (Rodham *et al.*, 2013). At the same time, given the uniqueness of the context and complexity of the target group, this is also necessary for careful interpretation. Finally, it is recommended to examine the perspective of socio-therapists with regard to group climate in follow-up research.

This study underlines the complex task assignment of socio-therapists in forensic care for clients with MID-BIF. Group climate must be attuned to their specific characteristics, needs, learning style inherent to MID-BIF, mental disorders and risky behavior, while at the same time risks and safety must be monitored. High-quality and effective treatment requires the integration of knowledge and skills from forensic care, psychiatry and care for individuals with MID-BIF. By training socio-therapists to highlight risks based on the functioning profile and development history of individuals with MID-BIF, it is expected that group climate, and thus, the clinical, forensic treatment, will be better connected and have an effect in terms of reducing risky behavior. We, therefore, recommend investing in the knowledge, skills and attitude of socio-therapists with regard to identifying, interpreting and intervening on the living group. This study contributes by providing a framework (i.e. a mixer) to "fine-tune" group climate on five dimensions. Training socio-therapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimizing the group climate in a way that acknowledges the unique person in his or her specific context, which is in line with the broader trend of person-centered care in which the "one size fits not all" principle applies (Håkansson Eklund *et al.*, 2019).

Note

1. Throughout this paper the term "socio-therapist" is used to describe the role of a professional caregiver.

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